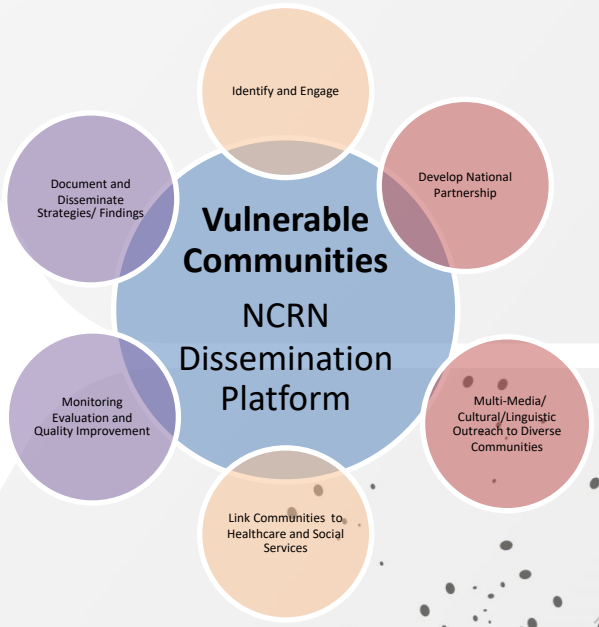

Modeling SUD Equity

MSM-OMH/HHS

The National COVID-19 Resiliency Network (NCRN)

Mitigating the Impact of COVID-19 on Vulnerable Populations

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Professor, Family Medicine
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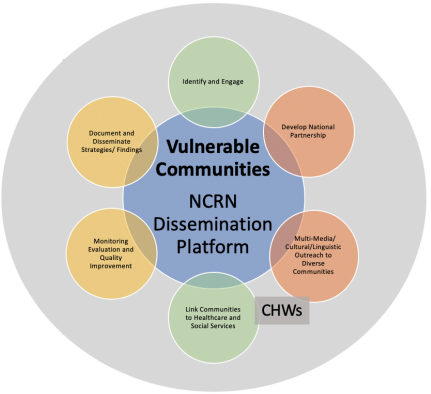
Goal: Mitigate the Impact of COVID-19 on Vulnerable Populations



Objectives

1) Identify and engage vulnerable communities through local, state, territory, tribes and national partners.

2) Nurture existing and develop new partnerships to ensure the NCRN is an active information dissemination network.

3) Partner with vulnerable communities and national, state, local, and government organizations to provide and disseminate culturally and linguistically appropriate information throughout states, territories, and tribes.

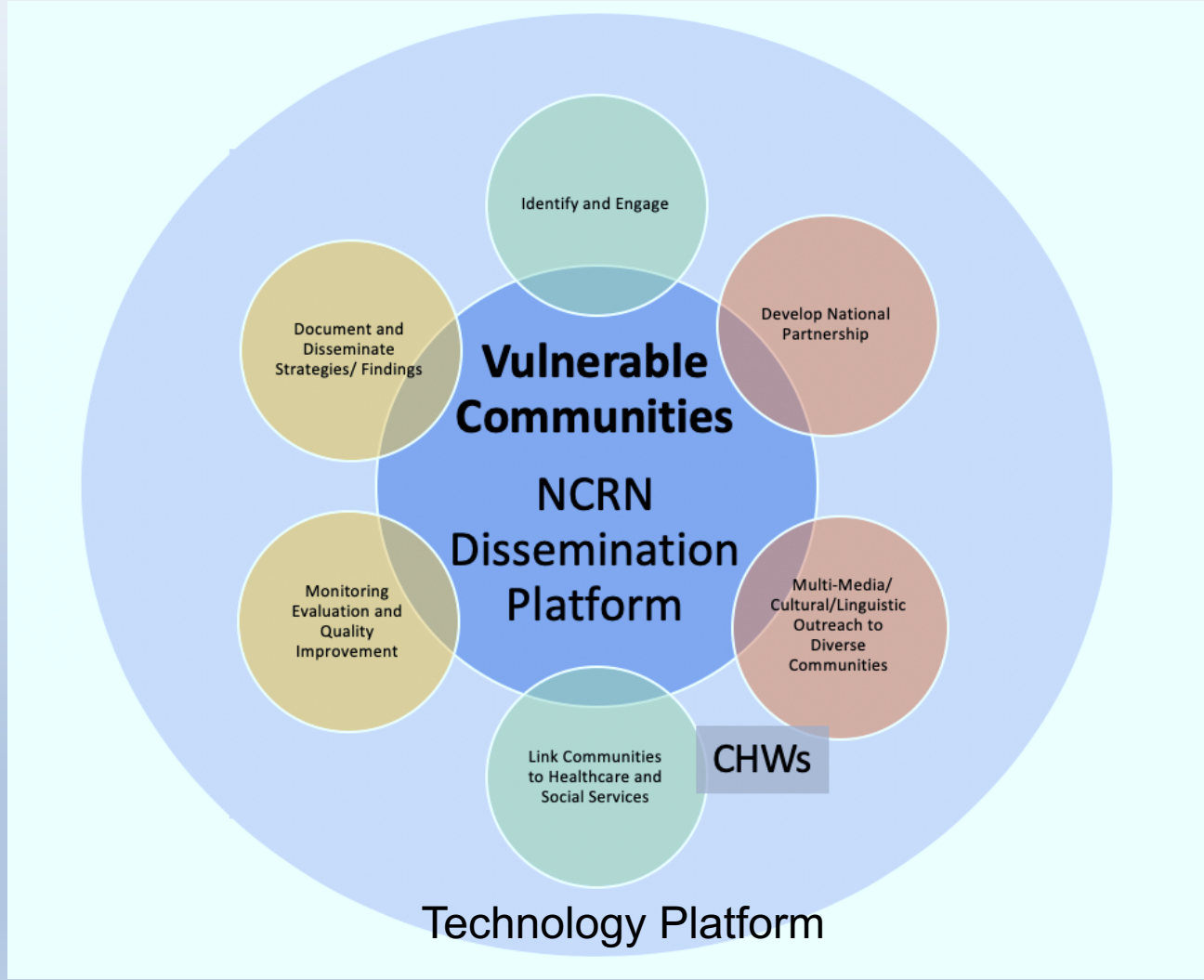
4) Use technology to link members of the priority vulnerable communities to community health workers, COVID-19 healthcare and social services, including testing, vaccinations, behavioral health counseling, and links to primary care practices.

5) Monitor and evaluate the success of the services and measure outcomes using process improvement methods to improve the quality of the overall program.

6) Use broad and comprehensive dissemination methods, including mainstream media, white papers, and publications as resources and strategies to add to the body of scientific knowledge and to bring awareness, participation, education and training.

The National COVID-19 Resiliency Network (NCRN)

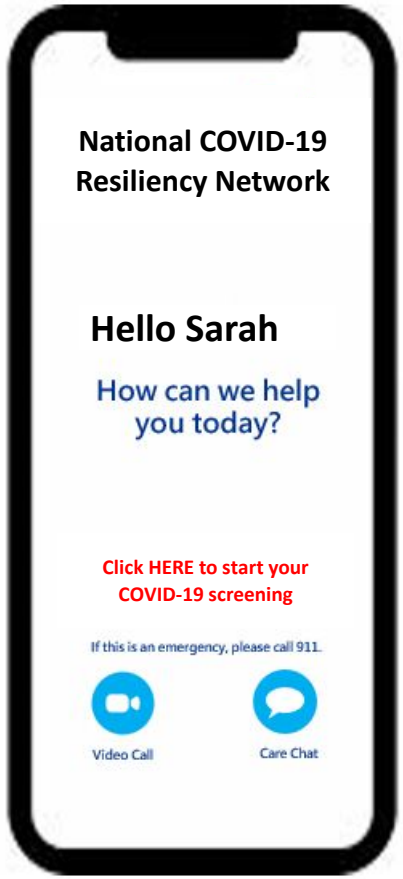
Mitigating the Impact of COVID-19 on Vulnerable Populations



ZIP CODE/COMMUNITY → CULTURE→ RISK → TESTING → CARE

Accelerating Consumer Engagement Technologies

Leverage existing subject matter professionals to leverage key partnership and scale services in response to COVID-19



Digital Presence
COVID-19 Digital triage process via web and mobile applications

Chat Bot
Symptom Checker, testing locator and general information inquiries to help drive consumers to the right channels for their needs.

Virtual-Collaboration
Provide a platform for public partnerships and organizations to collaborate and manage resources for individuals and communities at scale

Telco/Telehealth
Work with affiliated health system partners to offload volume of patient inquiries around testing, medication management, education, refills, etc.,

Outreach Services
Proactively reach out to individuals and communities with resource to assist with COVID-19 transportation needs to assist with coordination and delivery

- Ability to deploy technology in multiple languages may be offered
- Also state that appropriate federal and state privacy rules will be incorporated into the solution.

NCRN Partnerships (Year 1)

Partner Capabilities

- ✓ Connection with Racial and Ethnic Groups
- ✓ Reach/Breadth
- ✓ Ability to Communicate with community
- ✓ Boots on the Ground Capability (CHWs)
- ✓ Existing Resources

National

- Strategic Partners (#40 organizations)

State, Territory and Tribes

- State OMH, Public Health (#52 organizations)

Community

- CBOs, Health Systems, Local Organizations (#300 organizations)

CHWs (#2000 individuals)

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Community Partner	National	State Specific	All Racial and Ethnic Groups	Asian Pacific Islander	African Diaspora	Latinos	Alaskan Natives	Native Americans	Meat Packing Workers	Disabled	Migrant Workers	Prison Population
UNIDOS US	1		0	0	0	1		0	1	0	1	0
National Latino Behavioral Health Assoc.	1		0	0	0	1		0	1	0	1	0
University of TX El Paso (migrant workers)	0	1	0	0	0	1		0	1	0	1	0
Charles Drew University Medical School	0	1	0	0	1	1		0	0		0	0
100 Black Men of America	1		0	0	1	0		0	0	0	0	0
Asian & Pacific Islander American Health Forum (APIAHF)	1		0	1	0	0		0	0	0	0	0
National Council on Urban Indian Health	1		0	0	0	0		1	0	0	0	0
Alliance for Strong Families and Communities	1		1	1	1	1	1	1	0	0	0	0
Center for Victims of Torture	1		0	0	1	1		0	0	0	0	0
United Front for the Haitian Diaspora	1		0	0	1	0		0	0	0	0	0
Association of Asian Pacific Community Health Organizations (AAPCHO)	1		0	1	0	0		0	0	0	0	0
National Association of Community Health Workers (NACHC)- Health Resources in Action	1		1	1	1	1	1	1	1	1	1	1
University of Alaska Fairbanks' Center for Alaska Native Health Research (CANHR)	0	1	0	0	0	0	1	1	0	0	0	0
LINKS	1		0	0	1	0		0	0	0	0	
Institute for eHealth Equity/AME	0		0	0	1	0		0	0	0	0	0
Association of University Centers on Disabilities (AUCD)	1		1	1	1	1	1	1	0	1	0	0
University of Hawaii (Asian Pacific Islanders)	1		0	1	0	0		0	0	0	0	0
Dream Corp	1			1	1	1		1	0	0	0	1
number of organizations serving a specific group	14	3	3	7	10	9	4	6	4	2	4	2
% of all organizations servicing the group (total Organizations -18)	78%	17%	17%	39%	56%	50%	22%	33%	22%	11%	22%	11%

National COVID-19 Resiliency Network Five Priority Communities Impacted by COVID 19 (Phase 1)			
State/Territory	**Priority Areas**	**Vulnerable Communities**	**Reasoning (all communities touch HPSAs)**
Florida **Georgia**	Jefferson & Taylor County South	African American Hispanic Migrant Workers	Rising COVID-19 infection rates among African Americans and Migrant Farm Workers
Louisiana	Orleans, Jefferson, East Baton Rouge Parishes	African American Incarcerated	Quick rise in cases and deaths, 2nd highest incarcerated population in US, need for culturally appropriate approach for African Americans
Navajo Nation	Reservation touches Arizona, New Mexico, Utah	Native Indian	Largest American Indian population with the highest infection rate and most deaths; Need for additional culturally relevant resources
California **Hawaii**	Los Angeles Hawaii, all counties	African American Asian Pacific Islanders Hispanic	CA has Highest cases in US Asian Pacific Islanders highly impacted in CA and HI
Rural consortium **Texas** **Alaska**	El Paso, Moore County Anchorage	Hispanic Migrant workers • Meat Packing • Farmers Alaskan Native	Migrant Meat Packing and Farmer industry highly impacted Alaskan Natives at higher risk for COVID-19 related morbidity and mortality

Modeling Health Equitable Programs

Journal of the National Medical Association

Available online 23 October 2020

In Press, Corrected Proof

Disaster Preparedness and Equitable Care during Pandemics

Dominic H. Mack M.D., M.B.A., Carmen Hughes M.B.A., Megan Douglas J.D., Anne Gaglioti M.D., M.S., F.A.A.F.P.

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https://doi.org/10.1016/j.jnma.2020.09.149

Disasters don't discriminate against individuals because of their race or ethnic background, but health systems have implicit challenges that do.[1] Today's COVID-19 tempestuous atmosphere of social and political uncertainty should remind this nation of Hurricane Katrina's impact on the determinants of health in minority communities. Many of us witnessed the infamous

PETAL Framework

We have developed the PETAL framework, the first to apply a health equity lens to a learning health system (LHS) approach to transform healthcare organizations and communities.

Prioritize Health Equity

Engage Community

Target Health Disparities

Act on Data

Learn and Improve

Publications (public access)

PREVENTING CHRONIC DISEASE
PUBLIC HEALTH RESEARCH, PRACTICE, AND POLICY
Volume 17, E83 AUGUST 2020

COMMENTARY

Community Engagement of African Americans in the Era of COVID-19: Considerations, Challenges, Implications, and Recommendations for Public Health

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Accessible Version: www.cdc.gov/pcd/issues/2020/20_0255.htm

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PEER REVIEWED

Summary

What is already known on this topic?

African Americans are more likely to contract coronavirus disease 2019 (COVID-19), be hospitalized for it, and die of the disease when compared with other racial/ethnic groups. Psychosocial, sociocultural, and environmental vulnerabilities, compounded by preexisting health conditions, exacerbate this health disparity.

What is added by this report?

This report adds to an understanding of the interconnected historical, policy, clinical, and community factors associated with pandemic risk, which underpin community-based participatory research approaches to advance the art and science of community engagement among African Americans in the COVID-19 era.

What are the implications for public health practice?

When considered together, the factors detailed in this commentary create opportunities for new approaches to intentionally engage socially vulnerable African Americans. The proposed response strategies will proactively prepare public health leaders for the next pandemic and advance community leadership toward health equity.

Abstract

African Americans, compared with all other racial/ethnic groups, are more likely to contract coronavirus disease 2019 (COVID-19), be hospitalized for it, and die of the disease. Psychosocial, sociocultural, and environmental vulnerabilities, compounded by preexisting health conditions, exacerbate this health disparity. Interconnected historical, policy, clinical, and community factors explain and underpin community-based participatory research approaches to advance the art and science of community engagement among African Americans in the COVID-19 era. In this commentary, we detail the pandemic response strategies of the Morehouse School of Medicine Prevention Research Center. We discuss the implications of these complex factors and propose recommendations for addressing them that, adopted together, will result in community and data-informed mitigation strategies. These approaches will proactively prepare for the next pandemic and advance community leadership toward health equity.

Introduction

Racial/ethnic minority populations have historically borne a disproportionate burden of illness, hospitalization, and death during public health emergencies, including the 2009 H1N1 influenza pandemic and the Zika virus epidemic (1–4). This disproportionate burden is due to a higher level of social vulnerability — "individual and community characteristics that affect capacities to anticipate, confront, repair, and recover from the effects of a disaster" — among racial/ethnic minority populations than among non-Hispanic White populations (5). These characteristics include, but are not limited to, low socioeconomic status and power, predisposing racial/ethnic minority populations in general and African Americans in particular to less-than-optimal living conditions. Some racial/ethnic minority populations are more likely than non-Hispanic White populations to live in densely populated areas, overcrowded housing, and/or multigenerational homes; lack adequate plumbing and access to clean water; and/or have jobs that do not offer paid leave or the opportunity to work from home (6,7). These factors contribute to a person's ability to comply with

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Learning Health Systems

COMMENTARY

Developing a framework for integrating health equity into the learning health system

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Abstract

While there have been gains in the overall quality of health care, racial and ethnic disparities in health outcomes continue to persist in the United States. The Learning Health System (LHS) has the potential to significantly improve health care quality using patient-centered design, data analytics, and continuous improvement. To ensure that health disparities are also being addressed, targeted approaches must be used. This document sets forth a practical framework to incorporate health equity into a developing LHS. Using a case study approach, the framework is applied to 2 projects focused on the reduction of health disparities to highlight its application.

KEYWORDS

health equity, health information technology, social determinants of health

1 | BACKGROUND

Despite improvements in overall health care quality, inequities in health outcomes persist.[1] The World Health Organization (WHO) defines health inequities as "avoidable" differences in health between population groups caused by differences such as social and economic conditions.[2] Health disparities have been associated with individual-level factors such as race, ethnicity, gender and gender identity, sexual orientation, disability, and socioeconomic status.

In addition to being morally unacceptable, health inequities are costly, both financially and in terms of mortality and quality of life.[3,4] Life expectancy varies as much as 30 years between the richest and poorest US counties.[5] Between 2003 and 2006, the elimination of racial and ethnic health disparities is estimated to have saved $230 billion in direct medical expenditures and over $1 trillion in indirect costs.[6] Elimination of the black-white mortality gap would have prevented approximately 83 570 excess deaths in 2002.[7] And while health disparities continue to be prevalent, they can be eliminated. From 1990 to 2000, 10 US counties either sustained or moved toward equitable breast cancer mortality rates between black and white women.[8] In addition, significant improvements in black-white infant mortality rates were made in the last decade, with 30 states demonstrating a reduction of the gap.[9]

The mechanisms required to move towards equity are multifaceted and often unique to a given community due to differing resources, cultures, and priorities.[10] Many of these factors can be described using the umbrella term "social determinants of health" (SDH), which involve

WHITE PAPER

County-Level Proportion of Non-Hispanic Black Population is Associated with Increased County Confirmed COVID-19 Case Rates After Accounting for Poverty, Insurance Status, and Population Density

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Conflict of Interest: *The authors have no conflicts of interest to declare.*

Background:

Although there is sparsely available race- and ethnicity-specific epidemiologic data for COVID-19, the available data shows non-Hispanic black populations bear a disproportionate burden of COVID-19 cases and fatalities.[i,ii] There have been several potential causal pathways discussed in the media and the public health literature for these differences, including disproportionate employment in high-exposure fields, disproportionate burden of underlying health conditions, disproportionate burdens of poverty, and higher rates of uninsured status.[iii,iv,v] COVID-19 racial health disparities are striking in Georgia; 80% of all those hospitalized for COVID-19 during March 2020 in Georgia were non-Hispanic black.[vi] The Georgia Department of Public Health *(GDPH)* first reported COVID-19 positive cases by race and ethnicity in early April.[vii] At that time, more than 50% of the positive cases initially reported were of unknown race and ethnicity, leaving the true racial and ethnic breakdown unclear. As of April 27, 2020, 35% of positive cases in Georgia were among African Americans and the cases with unknown race had dropped to around 10%. However, Georgia's public data sources are not consistently reporting COVID-19-related deaths by race and ethnicity, so potential disparities in mortality remain unknown. In order to characterize areas with high COVID-19 burden, we examined

> "Given the context of the known racial disparities of COVID-19 at the individual level, we conducted this ecologic analysis to examine the association between the proportion of non-Hispanic blacks in the county and the confirmed COVID-19 case rate in the county.

county-level sociodemographic factors as predictors of county-level COVID-19 confirmed case rates using linear regression models. Given the context of the known racial disparities of COVID-19 at the individual level, we conducted this ecologic analysis to examine the association between the proportion non-Hispanic black population in the county and the confirmed COVID-19 case rate in the county.

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